

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Mission Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 East Medicine Lake Boulevard Plymouth, MN 55441	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident receiving hospice services had a comprehensive written plan of care included both the most recent hospice plan of care and a description of the services furnished by the facility to help the resident attain or maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (R1) reviewed for hospice services. Findings include: R1's hospital Discharge summary dated [DATE], identified R1's primary diagnoses included repeated falls, Parkinson's disease with dyskinesia and dementia with hospice care as discharge disposition. R1's hospice initial coordination note dated 2/10/26 indicated goals related to pain management as well as the initial visit frequency (once a week for nursing staff and once a month for social workers) but none of these goals or interventions were integrated into the facility's care plan. The note further indicated hospice will deliver to the facility the initial plan of care for R1 which was not provided to the surveyor upon request. R1's activity of daily living (ADLs) care plan dated 2/10/26 showed no inclusion of the most recent hospice plan of care (POC) and did not contain any documentation of how the facility would coordinate or provide services to support the hospice interventions. Review of the February R1's medical record showed R1 did not have a comprehensive written plan of care including both the most recent hospice and the services the facility would provide to support the hospice plan of care such as nursing interventions, activities of daily living assistance and pain monitoring. During an interview on 3/5/26 at 1:04 p.m., a nursing assistant (NA)-A stated she knew R1 was on hospice but did not know the specifics of his hospice care needs. NA-A explained she had not been informed of hospice-specific interventions such as the required frequency of pain monitoring or comfort-focused approaches to assisting with (ADLs). During an interview on 3/5/26 at 1:59 p.m., a registered nurse (RN)-A, stated R1 was on hospice care when he was admitted to the facility. RN-B explained R1's comprehensive care plan should reflect individualized goals and interventions to address his hospice care needs. RN-B confirmed she was unable to locate a comprehensive hospice care plan in R1's medical record, explaining that R1's care plan did not include the hospice-specific goals or interventions necessary to guide staff in meeting R1's needs. During an interview on 3/5/26 at 2:50 p.m., RN-B, a hospice nurse stated R1 was enrolled in a hospice care when he was admitted to the facility on [DATE]. RN-A explained she did not provide R1's comprehensive hospice plan of care to the facility, explaining that her primary focus at the time was on R1's medication management. RN-A stated staff should have access to a hospice plan of care which identified R1's needs and focus interventions to prevent unnecessary decline. During an interview on 3/5/26 at 3:55 p.m., the director of nursing (DON) stated the facility relied on hospice to manage their plan of care. The DON reported she was unaware whether the hospice plan of care had been integrated into R1's comprehensive care plan. The DON explained she expected nursing staff to follow R1's individualized care plan, including his hospice related goals and interventions. The DON stated nurse manager should have initiated R1's comprehensive care plan, including the hospice plan of care, but she did not recall whether this had been completed. The DON further explained hospice residents' care plans should include interventions (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for pain management, anxiety, shortness of breath management, and psychosocial support, but she could not confirm whether these interventions were present in R1's care plan. The facility comprehensive care plan policy was request but not provided. The facility resident assessment policy with no date required a comprehensive care plan for all residents admitted to the facility.</p>		